UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
REGION 17

COUNCIL BLUFFS, IA

JENNIE EDMUNDSON MEMORIAL HOSPITAL[1]

Employer

and

Case 17-RC-12682

MINNESOTA NURSES ASSSOCIATION affiliated with
NATIONAL NURSES UNITED/AFL-CIO [2]

Petitioner

DECISION AND DIRECTION OF ELECTION

Upon a petition duly filed under Section 9(c) of the National Labor Relations Act, as amended, a hearing was held on October 26 through October 28, 2010, before a hearing officer of the National Labor Relations Board, hereinafter referred to as the Board, to determine an appropriate unit for collective bargaining.[3]

I. ISSUES

Petitioner Minnesota Nurses Association affiliated with National Nurses United / AFL-CIO (the Union) seeks an election in a unit including all professional registered nurses employed by

[1] The Employer's name appears as stipulated by the parties.
[2] The Petitioner's name appears as stipulated by the parties.
[3] Upon review of the entire record in this proceeding, the undersigned finds:

a. The hearing officer's rulings made at the hearing are free from prejudicial error and are hereby affirmed.

b. The Employer is engaged in commerce within the meaning of the Act and it will effectuate the purposes of the Act to assert jurisdiction herein. Commerce facts: Jennie Edmundson Memorial Hospital, the Employer, a non-profit corporation incorporated in the State of Iowa, is engaged in the business of providing acute care hospital services. During the past year, a representative period, the Employer derived gross revenues valued I excess of $1,000,000. The Employer purchased services valued in excess of $50,000 directly from sources outside the State of Iowa, and the Employer's gross revenue from sales or performance of services to customers outside the State of Iowa exceeded $50,000.

c. The labor organization involved claims to represent certain employees of the Employer.

d. A question affecting commerce exists concerning the representation of certain employees of the Employer within the meaning of Section 9(c)(1) and Section 2(6) and (7) of the Act.

Jennie Edmundson Memorial Hospital (the Employer) at its Council Bluffs, Iowa facility who function as staff nurses and charge nurses. The number of nurses petitioned for by the Union number approximately 177. The Employer's contentions concerning the Union's petition are fourfold. First, the Employer contends that the Petition should be dismissed because its collective-bargaining agreement with the Iowa Nurses Association (the INA) covering the petitioned for employees operates as a bar to the instant petition, and that any efforts by the INA to disclaim interest in representing the nursing unit were both untimely and invalid because it was done in collusion with Petitioner. Second, the Employer asserts that 43 of its 177 registered nurses perform regular and substantial charge duties, which render them supervisors under the Act. Third, the Employer asserts that its Options Nurses who performed at least 4 hours of work each week over a 13 week period should be included in the unit using the Board's formula set forth in *Davison-Paxon*, 185 NLRB 21 (1970). Fourth, without taking a position regarding inclusion or exclusion, the Employer presented evidence to support that employees working in the job classifications of certified lactation consultant, wound-ostomy-continence registered nurse, breast health center coordinator, registered nurse/patient care coordinator, wound care case managers, patient service coordinators, pre-admission registered nurse, employee health nurse, and assistant coordinator family health should be included in the unit because they share a sufficient community of interest with those nurses petitioned for by the Union. [4]

The Petitioner disagrees with the Employer's contention that the INA's collective-bargaining agreement bars its petition to represent the Employer's staff nurses, arguing that the timing of the disclaimer in relation to the filing if the petition is of no consequence and that there was no collusion between itself and the disclaiming union, which would render the INA's disclaimer invalid. The Petitioner further urges that Respondent's charge nurses are not supervisors under the Act, and instead,

[4] Apart from the specific positions at issue, there was no contention at the hearing that a unit of registered nurses is otherwise inappropriate. The Employer is an acute care hospital. As the Employer is an acute care hospital, the Board's Healthcare Rules that issued on April 21, 1989, and set forth at 284 NLRB 1515, et seq, are applicable in this matter, and a unit comprised of Registered Nurses is an appropriate unit under the Board's Rules.

amount to mere lead employees. The Petitioner does agree that the Employer's options nurses, with the exception of options nurse Heidi Watts, who Petitioner contends is a supervisor, should be included in the unit if they meet the Board's *Davison-Paxon* formula because they share a community of interest with the petitioned for registered nurses. Finally, other than three classifications of patient service coordinator, employee health nurse and assistant coordinator family health, the Petitioner agrees that the remaining employees serving in the classifications of certified lactation consultant, wound-ostomy-continence registered nurse, breast health center coordinator, registered nurse/patient care coordinator, wound care case managers, and pre-admission registered nurse share a sufficient community of interest with the petitioned for employees. The Petitioner has agreed that it will proceed to an election in the unit found appropriate in this Decision and Direction of Election.

II. DECISION

For the reasons discussed in detail below, it is first concluded that the collective-bargaining agreement between the Employer and the INA does not act as a bar to the Petition filed by the Union.[5] Second, using the Board's analysis as outlined in the *Oakwood* trilogy, [6] it is concluded that the Employer has failed to establish that the charge nurses are supervisors within the meaning of Section 2(11), and they will be eligible to vote in the election ordered herein. Third, it is concluded that options registered nurses should be included in the unit found appropriate using the *Davison-Paxon* formula. Finally, the certified lactation consultant, wound-ostomy-continence registered nurse, breast health center coordinator, registered nurse/patient care coordinator, wound care case managers, and

[5] Employer's counsel contends that the Region issued its Order Revoking Status of the Union (the INA) on October 20, 2010, over the known opposition of the Employer and without allowing the Employer an opportunity to address its concerns over the timeliness of the INA's disclaimer. Employer's counsel's assertions do not reflect the conversations between the Region and the Employer's former counsel related to the effectiveness of the disclaimer, which occurred before issuance of the Region's Order Revoking Status of the Union, and prior to Employer's counsel's entry of appearance on October 20, 2010, the same day as issuance of the Order Revoking. In any event, the Employer, through its counsel, was given a full opportunity at the hearing in this matter to review subpoenaed records and to present evidence related to its disclaimer concerns. As such, any harm the Employer complains of from the Region's October 20 issuance of the Order Revoking Status of the Union is of no import.

[6] *Oakwood Healthcare Inc*., 348 NLRB 686 (2006); *Croft Metals, Inc*., 348 NLRB 717 (2006) and *Golden Crest Healthcare Center*, 348 NLRB 727 (2006).

pre-admission registered nurse share a sufficient community of interest with other registered nurses to be included in the appropriate unit and will be eligible to vote in the election ordered herein. On the other hand, patient service coordinators, employee health nurses and assistant coordinators/family health serve do not share a sufficient community of interest with other registered nurses appropriately included in the unit because they are not required or effectively required to be registered nurses to hold their positions. As such, they will be excluded from the unit found appropriate.

Accordingly, the following employees of the Employer constitute a unit appropriate for the purpose of collective bargaining with in the meaning of Section 9(b) of the Act.

> All full-time and regular part-time registered nurses, including charge nurses, options registered nurses, certified lactation consultants, wound-ostomy-continence registered nurses, breast health center coordinators, registered nurse/patient care coordinators, wound care case managers, and pre-admission registered nurses, employed by the Employer at its facility located in Council Bluffs, Iowa, but EXCLUDING, patient service coordinators, employee health nurses, and assistant coordinators/family health, guards and supervisors, as defined in the Act.

There are approximately 209 employees employed by the Employer in the unit found appropriate herein.

III. STATEMENT OF FACTS

A. Background of Filing of the RC Petition and Disclaimer

Since 1966, the INA has represented certain of the Employer's nurses at the hospital campus in Council Bluffs, Iowa. The most current collective-bargaining agreement between the INA and the Employer is effective by its terms from March 8, 2008 through March 9, 2012, and defines the unit as those professional registered nurses regularly employed by the Employer a minimum of 16 hours per pay period or more, and who function as staff nurses or charge nurses. The collective-bargaining agreement's provisions specifically reference agency and options nurses as outside of the unit.

Based on email correspondence introduced at the hearing, it appears that the INA was engaged in a dispute with the National Nurses United (NNU), a federated labor organization formed in or

around November 2009. The NNU's formation was based on the merger of the California Nurses Association and the Minnesota Nurses Association, and the concurrent dissolution of United American Nurses (UAN). Based on record evidence, it appears that the INA's executive director Linda Goeldner believed that the formation of the NNU was improper and desired to disaffiliate from, and in fact believed that INA was never affiliated with the NNU based on this belief.

However, in May 2010, Local 933 of the INA, the Local Union affiliated with the INA at the Employer's hospital, voted to remain affiliated with the NNU, and instructed the INA, as their representative, to transmit employees' membership dues to the NNU so that Local 933 would remain a member in good standing. According to Goeldner, it was this May 2010 vote of Local 933 to remain affiliated with the NNU that prompted the INA's move to disclaim interest in representing the Employer's nurses and the MNA's move to take over that representation.

Executive Director Goeldner further testified that the INA disclaimed interest in representing the Employer's employees because it could no longer afford to engage in collective bargaining on behalf of the nurses in the Employer's collective-bargaining unit, as well as other nurses in other units it had historically represented. Goeldner testified that in the last year its membership base was only 358 members and that it could not staff a collective bargaining program on the aggregate dues from that number of members. In fact, despite its obligation to represent the Employer's registered nurses, because of INA's financial difficulties, it could not and did not assist unit employees with the negotiation of the 2008 collective-bargaining agreement, and Local 933 was forced to hire a consultant with their own resources to assist them in bargaining. Goeldner further testified that the INA has been unable to assist the Employer's unit employees with any grievances, and instead, merely refers the local union to retain counsel.

At a meeting on August 26, 2010, Local 933's officers learned from Goeldner that the INA had determined that it would no longer engage in collective bargaining for registered nurses after January 1, 2011. At the time of this meeting, the INA represented nursing units not only at the employer's

facility, but also at the Marshalltown Hospital in Marshalltown, Iowa, the VA Hospital in Des Moines, Iowa, and the Mitchell County Hospital, in Osage, Iowa. Correspondence between INA and NNU during this time period shows that the INA, because of its apparent enmity with NNU, determined that it would disclaim interest in representing the Employer's unit employees, and would not oppose the movement of representative responsibilities for the Employer's employees to NNU's affiliate the MNA. Not only did INA disclaim interest in representing the Employer's employees, at the time of the hearing, the only hospital where the INA had not disclaimed its interest in representing nurses was at the Mitchell County Hospital, whose contract is effective into 2011. Goeldner testified that she is unsure what will happen to the Mitchell County unit after their contract is up in 2011.

Goeldner unequivocally testified that the INA is unable and unwilling to continue representing the Employer's unit employees. Goeldner testified that while the INA will no longer be engaged in collective-bargaining for nurses, it will continue, through its participation in the American Nurses Association, to advocate and lobby on behalf of nurses issues in the State of Iowa.

The specifics of the INA's disclaimer in the instant case arose at about 10:00 a.m. on October 13, 2010, at a monthly labor/management meeting between INA Local 933 and the Employer's representatives. Dan Engelhart, organizer with MNA attended the monthly labor/management meeting with the Local 933 representatives. During the meeting Local 933 President Doris Ballantyne handed the Employer representatives an October 13, 2010, letter signed by INA's Linda Goeldner, which disclaimed INA's interest in representing the unit nurses working for the Employer. Engelhart then explained that the unit employees desired representation by the MNA, and that the MNA had documents to support that majority support. Engelhart told the Employer representatives that the MNA would like the Employer to voluntarily recognize them and that they would replace the INA as the unit's representative. Engelhart further explained that they wanted the contract to stay in effect through its expiration, but that MNA would step in as the representative, rather than the INA. Ballantyne, relying on Goeldner's August 26 statement that the INA would not be representing

employees for collective bargaining after January 1, 2011, told the Employer representatives at the meeting that the INA's disclaimer would be effective on January 1, 2011. Because of the confusion as to the effective date of the disclaimer, on October 14, 2010, the Employer's President and CEO Steve Baumert wrote to Goeldner for clarification as to the timing of the disclaimer. In response, on October 14, 2010, Goeldner again disclaimed the INA's interest in representing the Employer's nurses effective immediately.

At about the same time as the labor/management meeting on October 13, 2010, the MNA's Representative Ben Fisher traveled from Minneapolis/St. Paul to Region 17's offices in Overland Park, Kansas and at about 8:40 a.m. filed an RC Petition and a disclaimer signed by Goeldner, disclaiming the INA's interest in representing the Employer's registered nurse unit.

While the INA disclaimed interest in representing the Employer's unit employees, the Employer has continued to check-off and transmit dues to the INA. The INA has received those dues and has not returned them to the Employer.

B. Overview of Operations and Managerial Structure

The Employer provides acute health care services, including emergency services, orthopedic/oncology/general medical (ortho/neuro), adult and pediatric medical/surgical services, in-patient psychiatric services, cardiac telemetry services, intensive care services (ICU), OB/GYN services, and surgery and outpatient surgery services at a hospital campus in Council Bluffs, Iowa.

For organizational and patient care purposes, the Employer has divided itself into a number of units mirroring the services that it provides: the Emergency Center consisting of 11 beds, staffed by approximately 19 registered nurses, 6 of whom the Employer says are supervisory charge nurses; Ortho/Neuro consisting of 23 beds, staffed by approximately 23 registered nurses, 5 of whom the Employer asserts are supervisory charge nurses; Adult and Pediatric Medical/Surgical Services, staffed by approximately 14 registered nurses, 6 of whom the Employer asserts are supervisory charge nurses; Psychiatric Services, an inpatient behavior health unit, consisting of 18 beds, staffed by approximately

11 registered nurses, 5 of whom the Employer asserts are supervisory charge nurses; Cardiac Telemetry Services, consisting of 28 beds, staffed by approximately 24 registered nurses, 5 of whom the Employer asserts are supervisory charge nurses; the ICU, consisting of 13 beds, staffed by approximately 21 registered nurses, 6 of whom the Employer asserts are supervisory charge nurses, the Birthing Center, consisting of 7 delivery rooms, 2 observation rooms, and 5 surgery rooms, staffed by approximately 18 registered nurses working in distinct categories as either labor and delivery nurses or mom/baby nurses, 4 of whom the Employer asserts are supervisory charge nurses; and Outpatient Surgery, including Endoscopy, staffed by approximately 14 registered nurses, 6 of whom the Employer asserts are supervisory charge nurses. [7] The Employer also employs licensed practical nurses, (LPNs), certified nurses assistants and unit secretaries in most of these departments.

The Employer's units are supervised by departmental directors. The Employer also utilizes a house supervisor who is at the hospital at all hours to handle the placement of patients, to serve as a resource person, and to deal with staffing needs during hours when the department directors are not present.

The Employer's managerial hierarchy includes Vice President of Patient Services Peggy Helget, who supervises all of the directors over the Employer's six departments - the Emergency Center; Ortho/Neuro and Adult and Pediatric Medical/Surgical Services; Psychiatric Services; Cardiac Telemetry and ICU; the Birthing Center; and Main Surgery, PACU (the main surgery recovery room), Outpatient Surgery and Sterile Processing. Donna Hubbell is the Employer's Vice President of Quality & Patient Safety who oversees several departments, including the Breast Clinic, Radiation Oncology, and Patient Scheduling and Pre-admissions, departments which include some of the

[7] In addition to its outpatient surgery department, the Employer also operates a main surgical department and main recovery room. The recovery room is otherwise known as PACU, and is referenced as such in record evidence. The employer's main surgical department and main recovery room is supervised by Surgery Manager Carol Deitchler, who the parties stipulated is a supervisor under the Act. Deitchler reports directly to Director of Surgery Marsha Joens, who the parties also agree is a supervisor under the Act. Deitchler directly supervises 41 employees, 18 of whom are registered nurses in the main surgery department and main surgical recovery room. The Employer presented no evidence that there are any charge nurses in the main surgical department or main recovery room.

classifications disputed at the hearing such as patient service coordinator and pre-admission registered nurse. The Employer also employs Becky Henkel, Director of Nursing Services, who manages the House Supervisors, the Float Pool or Personnel Pool and Specialty Nursing Services, departments which include some of the classifications disputed at the hearing such as the nurse practice coordinator and the wound care nurse.

The Employer's directors who report to Vice President Peg Helget are: the Director of the Emergency Center – Courtney Schmid; the Director of Psychiatric Services – Lora Cobbs[8]; the Director of Ortho/Neuro and Adult and Pediatric Medical/Surgical – Mary Colburn; the Director of Cardiac Telemetry and ICU – Teresa Stevens; the Director of the Birthing Center – Sandy Bertelsen; and the Director of Surgery, PACU, Outpatient Surgery, and Sterile Processing (collectively called Surgery) – Marsha Joens. The Parties stipulated that the above-individuals possess at least one of the supervisory authorities enunciated in the Act and should be excluded from the appropriate unit. Based on the Parties' stipulation, I will exclude the above-named individuals from the unit because they are supervisors under Section 2(11) of the Act.

Working under the Director of Surgery Joens is Surgery Manager Carol Deitchler who the parties stipulated should be excluded from the appropriate unit because she is a statutory supervisor. Based on the parties' stipulation, I will exclude Deitchler from the appropriate unit.

The record further supports that the Wound Center, where the Wound Care Case Managers Kathleen McGinnis and Jerilyn Smith are employed, is supervised by Director John Meyer who is employed by Excel Care, which has a management contract with the Employer. Meyer reports to the Director of Rehabilitation Lisa Fidone who is a physical therapy assistant. Director of Rehabilitation Fidone reports directly to Vice President Helget. The Parties agreed that neither Meyer nor Fidone should be included in the appropriate unit because Meyer is not employed by the Employer and Fidone

[8] Lora Cobbs is not employed by the Employer, and instead, is employed by Horizon Health, which is a contract management company that specializes in managing behavioral health units within general hospitals.

is a statutory supervisor, as well as not being a registered nurse. Based on the Parties' agreement, I will exclude Meyer and Fidone from the unit found appropriate.

The Parties stipulated that the Breast Center and the Radiation Oncology Department where the Breast Health Center Coordinator Tammy Johnson and Oncology Registered Nurse/Patient Care Coordinator Barbara Kricsfeld work respectively are supervised by Michelle Kaufman and that Kaufman is a statutory supervisor, as well as not being a registered nurse. Based on the Parties' stipulation, Kaufman will be excluded from the unit found appropriate because she is not a registered nurse, in addition to being a supervisor. The Parties also concluded that registered nurses Jean Armstrong, Family Resource Coordinator and Donna Wellwood, Employee Health Coordinator, who work in the Family Health Information Unit and the Employee Health Unit respectively, are statutory supervisors as defined in the Act. Based on this stipulation concerning their supervisory status, Armstrong and Wellwood are excluded from the petitioned for unit.

Finally, the Parties were in agreement that house supervisors are supervisors as defined in the Act. Based on the parties' agreement, and the record evidence concerning their duties and responsibilities which support that they possess supervisory authority, I will exclude house supervisors from the unit because they are statutory supervisors under the Act.

C. Charge Nurses

In the past, the Employer used registered nurses who were specifically designated with the title of "charge nurse" in many of its medical departments[9]. However, the Employer currently does not utilize the title of charge nurse to designate which of its registered nurses perform charge nurse functions, with the exception of two registered nurses who retain the historical title of charge nurse – Rosalie Fennell and Janel Allen – but the remainder of the registered nurses that the Employer

[9] The evidence supports that the Employer does not currently use charge nurses in its main surgical unit and its main recovery room, the float pool, radiology and cardiopulmonary rehabilitation where staff registered nurses are employed. While registered nurses from some of those units may have attended the Employer's new charge nurse training, the evidence does not show that they have been regularly performing duties as charge nurses.

contends are charge nurse supervisors are indistinguishable by title from other staff nurses. The collective-bargaining agreement between the Employer and the INA contains reference to charge nurses and contains a negotiated provision calling for a three dollar per hour premium for nurses acting as charge nurse.

In the Spring of 2010, the Employer began implementing a new charge nurse training program, based on its desire to standardize the position of charge nurse throughout the hospital. Prior to its implementation, the Employer met with Local 933 representatives to discuss its desire to implement a new written job description and evaluation form for charge nurses and to schedule a four hour charge nurse training. During these discussions, INA Local 933 President Doris Ballantyne advised the Employer's Vice-President Helget that the Union was concerned that the proposed changes to the written job description would render the employees participating in the charge nurse training and performing those prescribed duties supervisors, and consequently remove them from the bargaining unit. Helget repeatedly assured Ballantyne that the Employer's intention was not to remove employees from the bargaining unit. Prior to these assurances, the Employer had difficultly soliciting employee volunteers to participate in the charge nurse training, but based on Helget's assurances as to the Employer's intentions, registered nurses volunteered and participated in the Employer's August 12, 2010, Charge Nurse class. Of the approximately 177 unit employees, 75 attended the Employer's first charge nurse training session on August 12. The Employer anticipates additional training sessions on various issues, including a two-hour training session on Conflict Resolutions for Charge Nurses that was scheduled on four separate days in October and November 2010, and for which 82 of the 177 unit employees had volunteered to attend.[10]

[10] The Employer contends that 43 of the 82 employees who are attending the Employer's charge nurse training are supervisors because they perform supervisory duties regularly and substantially. While Vice-President Helget testified that of the other 39 registered nurses who have attended the Employer's training work as charge nurses on occasion, there is no evidence as to the amount of time that they perform charge duties.

Unit Directors are responsible for generating the work schedules for their respective departments. The vast majority of registered nurses are scheduled to work 12 hour shifts and work 72 hours every two weeks. Under the collective-bargaining agreement, registered nurses are allowed to self schedule and record evidence supports that some of the departments use self-scheduling. Charge nurses play no role in determining the positions, shifts, or schedules that other employees work.

In determining the number of employees scheduled to work at any given time, all of the Employer's departments use staffing benchmarks or matrices to determine the number of staff. These matrices are established for each department and are based on staffing hours per patient per day, with a goal of matching patient care requirements and nursing resources for each shift. For instance, Vice President Helget testified that the staffing matrix for ICU is 1 registered nurse per 2 patients, whereas in Medical/Surgical, the matrix is set at 1 registered nurse per 4 patients. As explained above, schedules are determined four weeks out under the provisions of the collective-bargaining agreement, with options (PRN) nurses being scheduled as far as six weeks out. If the nursing services office, which is managed by Director of Nursing Services Becky Henckel, in conjunction with the unit directors, determine prior to the shift that the shift is going to be over staffed based on low census, registered nurses will be called and told they will not be needed for their upcoming shift. The collective-bargaining agreement sets out specific procedures for determining who will be impacted by a low census day. Registered nurses are sent home in the order required by the collective-bargaining agreement. Charge nurses play no role in making these before shift, low census staffing determinations.

Staffing can also be adjusted throughout the day based on these departmental matrices. The matrices are adjusted based on the paperwork filled out in the departments reflecting admissions, transfers, and dismissals. The census paperwork is completed by the charge nurse on duty and the data is entered into the computer for use by the nursing services office to adjust staffing. Based on the various departmental staffing matrices, the nursing services office, in consultation with the unit

directors and/or house supervisors, use this information collected by the departments at 7 a.m., 11 a.m., 3 p.m., 7 p.m., and 11 p.m. to adjust staffing throughout the day. While providing this information to management, charge nurses do not make determinations to adjust daily staffing levels on their own.

During the course of the shift, if a department is overstaffed based on a drop in the patient census, the nursing services office, in conjunction with the unit directors or the house supervisors, may notify the charge nurse in the unit that a member of the staff will be floated to another unit; will ask the charge nurse to solicit volunteers to go home; or in the absence of volunteers, the charge nurse will use the on call rotation list specific to each unit to place an employee on call. The on call/call back system is contractually negotiated practice contained in the collective-bargaining agreement. The on call rotation lists keep track of who and when employees were placed on call and the individual with the fewest hours on call are sent home first.

If understaffed based either on the matrix, or based on increased need due to patient acuity, the charge nurse notifies the nursing services office who then determines if there is anyone available to float to the department needing extra staff. A charge nurse may request extra staff based on increased patient census, or on changes to patient acuity requiring staff in excess to the matrix, but the request may or may not be filled by the nursing services office.

Based on the Employer's written policies employees are required to call both their charge nurse and the nursing services office if they are going to be absent. Vice-President Helget testified that if an employee calls in sick, the nursing services office would automatically attempt to find a replacement without he input of the charge nurse.

The vast majority of the evidence presented to support the Employer's contention that charge nurses are supervisors relates to their ability to assign work to individuals in their departments, or to responsibly direct employees in the performance of tasks. Vice President Helget testified that charge nurses cannot hire employees, cannot permanently transfer employees from department to department, cannot suspend employees, cannot discipline employees, cannot discharge employees, cannot lay off

employees, cannot recall employees from layoff, cannot promote employees, cannot adjust employee grievances, and cannot evaluate or promote employees. There was minimal testimony presented that charge nurses might provide input into hiring decisions by sitting in on interviews and offering an opinion; might provide information to the unit director in evaluations by filling out peer reviews or providing other information; and could participate in disciplinary matters by presenting factual information to unit directors that could result in discipline. Helget testified, however, that all decisions on these matters fell to the Employer's unit directors. In fact, Vice President Helget testified that, while a charge nurse could report disciplinary matters to her director, all staff nurses would be expected to report potential disciplinary matters to the unit directors. Specifics of charge nurses input into supervisory decisions will be discussed below by department as appropriate.

Finally, the unit directors testified that employees can go to the charge nurse with work problems, but each also testified that all employees are allowed and do come directly to them, without going to the charge nurse. Further, while the testimony was clear that the employees can go to their charge nurses with problems, the charge nurses have no ability to adjust employee grievances, but instead, can merely raise the issue with the unit director.

1. The Emergency Center

Courtney Schmid is the Director over the Emergency Center. At the time of the hearing, Schmid had only served as Emergency Center Director for approximately three months. Schmid serves over a department, which employs approximately 41 employees, 19 of whom are registered nurses. The remainder of the staff is comprised of certified nurses assistants, and emergency room technicians. The Employer believes that 6 of the 19 registered nurses who serve as charge nurses are supervisors under the Act. Those nurses are Jean Carstensen, Amy Turner, Doris Ballantyne, Lisa Coldeway, Julie Hines, and Makaela Smith, all of whom worked in a charge capacity at least 16 hours per week over the 13 weeks preceding the hearing. While, the department employs 41 employees, they are not on duty concurrently, but rather rotate through the Emergency Center on the various shifts.

Schmid works from 6 a.m. to 5 p.m.. On any given shift that Unit Director Schmid works, only 2-3 staff nurses, 1 charge nurse, and 1 emergency medical care technician, who also operates as the unit secretary, are on duty. While he is on call, during Schmid's off hours, the house supervisor supervises 2-3 staff nurses, and 1 emergency medical care technician, who also operates as the unit secretary.

The Emergency Center contains 11 beds in 10 examination rooms. Staff in the Emergency Center work 12 hour shifts from 7 a.m. to 7 p.m. and 7 p.m. to 7 a.m.. The number of staff required in the Emergency center is dictated by the Employer's Core Standard. The number and identity of staff scheduled on a shift is determined by Courtney Schmid.

Assignment of patients to particular staff in the Emergency Room is handled by who is available when patients come into the Emergency Center. On the evening shift, Charge Nurse Jean Carstensen testified that from 7 p.m. to 11 p.m. they utilize a triage nurse who assesses the patient and then sends them to the exam rooms based on the severity of need. The triage nurse then assigns a nurse to assist that patient. The triage nurse assigns nurses to the patients based on who is available. The charge nurse chooses who will be the triage nurse, again based solely on who is available and rotates through the nurses, who are all equally qualified to serve in a triage position. After 11 p.m., nurses are assigned to patients solely by who is available. Many times, it is the nurse who went to the desk to take a patient to an examination room, who ends up staying with the patient for the duration of their care.

If it is determined by the nursing services office that the department is overstaffed, the charge nurse first asks for volunteers and then uses the rotational on call list to determine who should be sent home. If understaffed due to a sick employee, the charge nurse would first see if the nursing services office was going to be able to handle the absence through a float nurse or options nurse, if not, the charge would begin at the top of the list of employees coming on duty next and ask if they could come in early. The charge nurse cannot require that employees come to work. Charge nurse Ballantyne

testified that in an emergency, the charge nurse might be able to require employees to stay over their shift if patients' safety is in jeopardy.

As to assigning employees to discreet tasks, charge nurses can ask a certified nurses assistant to run an electrocardiogram, but the evidence shows that any nurse can ask a certified nurse assistant to perform this task.

Schmid testified that he has had charge nurses sit in on interviews and has accepted their recommendations on hiring. However, when asked to name the individuals who have assisted him with the interviews and whose recommendations he accepted, three of the four individuals he named are staff nurses not charge nurses.

Schmid further testified that a charge nurse could be disciplined if she didn't perform her charge duties appropriately. When asked in what circumstances this could happen Schmid testified that the charge nurses in his departments are responsible for three discrete tasks, one to check pending labs, another to do radiology over reads, and finally to check the crash cart. Schmid testified that if those tasks didn't get done on a daily basis by the Charge Nurse, there would be disciplinary action.

2. Ortho/Neuro and Adult and Pediatric Medical/Surgical Services

Mary Jane Colburn is the Director over the Ortho/Neuro unit and the Adult Pediatric Medical/Surgical unit. At the time of the hearing, Colburn's department employed approximately 85 employees, 37 of whom were registered nurses. The remainder of the staff in these two units is comprised of certified nurses assistants, licensed practical nurses, unit secretaries, and ward clerks. The Employer contends that 11 of the 37 registered nurses perform regular and substantial supervisory duties and should be excluded from the unit. Those nurses are Rosalie Fennell, Janice Anderson-Ulmer, Melanie Burnison, Sarah Colpitts, Rachel Dyke, and Jennifer Peare in Ortho/Neuro; and Kathryn Runda, Patricia Sievers, Christina Solt, Christine Weis, and Lori Gochenour in Adult and Pediatric Medical/Surgical Services, all of whom worked in a charge capacity at least 16 hours per week over the 13 weeks preceding the hearing. While, the department employs 85 employees, they are

not on duty concurrently, but rather rotate through the Ortho/Neuro unit and the Adult Pediatric Medical/Surgical unit on the various shifts. On any given shift that Colburn works, she supervises 7-9 staff nurses, 2 charge nurses, and 6-8 certified nurses assistants, and 2 unit secretaries. While on call, during Colburn's off hours, the house supervisor would supervise 6-8 staff nurses, 2 charge nurses, 6-8 certified nurses assistants, and 2 unit secretaries in both areas.

In the Ortho/Neuro unit and the Adult Pediatric Medical/Surgical unit nurses are assigned to patients by the charge nurse working on the previous shift. Near the end of the shift, the charge nurse is notified by the nursing services office of the staffing numbers for the following shift based on the patient census and matrix for each area. The charge nurse takes that information and uses the assignment sheet to assign the nurses on the oncoming shift to the patients that they will be working with during that shift. Charge nurses are not necessarily familiar with the skills and abilities of the nurses on the oncoming shifts. The charge nurse assigns nurses and other staff to patients with an eye to equalizing the number of patients assigned to each staff member. The charge nurses also attempt to assign patients based on the geographic proximity of the patient rooms, so that nurses and other staff are working in the same general area with their patient loads. Finally, the charge nurse may also look at continuity of treatment, and try to assign the same nurse and other staff to the patients that they have already been working with.

During their shift, the charge nurses may be notified by the nursing services office that their patient census has either dropped or increased with sufficiency to require a staffing adjustment. If overstaffed, the nursing services office first looks at a list in their office of employees that have requested to go home when patient census falls, if there is no one on that list, the nursing services office calls the charge and that charge nurse seeks volunteers. If no one volunteers, the charge nurse would use the rotational on call list specific to that area and send home the person based on the list. Even if that person were taking care of a particularly ill patient, if the list required that she be sent home, she would be sent home, and someone else would be assigned to that patient.

If there are new admissions or dismissals, according to Unit Director Colburn, the charge nurse seeks to equalize assignments. Charge Nurse Ulmer testified that when there is a new admission, she first sees if anyone volunteers to take the patient, and if not, looks to the nurses' PAL to see who is most available. PAL is a computerized program showing the nursing functions performed for the patients by each nurse. If a particular nurse's PAL shows that perhaps she is behind, she will probably not get the assignment. If needed, the charge nurse may request additional staff of the unit director or the house supervisor. Float nurses sent to the Ortho/Neuro and the Adult Pediatric Medical/Surgical units are all qualified to perform the work of the units and are assigned by the charge nurse with an eye toward equalization.

On the Ortho/Neuro unit and the Adult Pediatric Medical/Surgical unit nurses are required to fill out significant daily paperwork related to the patient census; handle the legwork and all paperwork for admissions, discharges, and transfers of patients; call doctors with any questions, finish doctor orders, fill out required forms for the pneumonia patients, fill out lab work for central lines and blood draws; and fill complete acuity sheets showing admissions, transfers and discharges. Charge nurses also verify attendance of the staff in their areas. The charge nurses also participate in rounds with the physicians on the floor. While it is up to the charge nurse to take patients themselves, it appears that charge nurses in the Ortho/Neuro unit and the Adult Pediatric Medical/Surgical unit on the day shift do not work with patients, while they do in the evenings, either for the whole shift, or at least after 11 p.m..

3. Psychiatric Services

Lora Cobbs is the Director over Psychiatric Services, which provides lock-down inpatient psychiatric care to patients, whose typical stay is four to five days. Cobbs serves over a department containing approximately 32 employees, 11 of whom are registered nurses. The remainder of the staff is comprised of licensed practical nurses, certified nurses assistants, staff assistants, unit secretaries, an occupational therapist, a chemical dependency therapist and a social worker. The Employer believes

that 5 of the 11 registered nurses who serve as charge nurses are supervisors under the Act. Those nurses are Lisa Boell, Henrietta Guttau, Mary Mahlberg, Denise Phippen and Ruth Reeves, all of whom worked in a charge capacity at least 16 hours per week over the 13 weeks preceding the hearing. While, the department employs 32 employees, they are not on duty concurrently, but rather rotate through Psychiatric Services on the various shifts. On any given shift that Cobbs works, she supervises 1-2 staff nurses or licensed practical nurses, 1 charge nurse, and 1 unit secretary, as well as 2 staff assistants, an occupational therapist, a chemical dependency therapist and a social worker. While on call, during Cobbs' off hours, the house supervisor would supervise 1-2 staff nurses or licensed practical nurses, 1 charge nurse, and 1 unit secretary. In addition to Cobbs' supervisory presence during the day, the unit also is staffed by a medical director. The record is silent as to the medical director's duties, other than that he/she does rounds daily with the physicians.

Psychiatric Services is an 18 bed in-patient behavioral health unit. Staff in the Psychiatric Services work 8 hour shifts from 7 a.m. to 3:30 p.m., 3 p.m. to 11 p.m. and 11 p.m. to 7:30 a.m. . The number of staff required in the Psychiatric Services is dictated by the Employer's matrix. The charge nurse takes a full share of patients, although it is possible they may take one or two patients fewer.

In deciding which patients are going to be assigned to a particular nurse, the evidence from both Charge Nurse Lisa Boell and Unit Director Lora Cobbs supports that as to those already admitted patients, assignment decisions are made during report, prior to the shift. The evidence establishes that assignments are made in a collegial or collaborative fashion, with nurses speaking up to say which patients they want to work with on a shift, either based on their rapport with that patient, or their desire to work with certain types of patients. Often patients remain with the nurse who handled their admission. In instances where this type of allocation does not work, it is the charge nurse's decision to assign nurses to the patients, although there is no evidence that this has happened. When new patients are admitted both Boell and Cobbs testified that patients are rotated to each nurse to equalize assignments. If a patient were violent to a nurse, the charge nurse could decide to reassign that patient

to another staff member. If a new nurse is assigned to a shift, the other two nurses both figure out which of their patients to give the new nurse.

As to assignments to certified nurses assistants, the patient census generally calls for one certified nurses assistant. That certified nurses assistant will handle taking vitals for all of the patients on the unit. If the census dictates that the unit staffs two certified nurses assistants, they decide between themselves which of them will handle the vitals, and other duties such as going through patients' belongs and assisting with visitors, while the other certified nurses assistant on duty will handle the required 15 minute checks on each patient in the unit.

If the matrix dictates that an employee should be sent home, the charge nurse cannot float an employee to another unit. Instead, the charge will call the nursing services office to see if the employee can be used somewhere. If not, the charge nurse uses the unit's contractual rotational on call list to send the employee home.

While Cobbs testified that a charge nurse may be held accountable for her charge duties, she acknowledged that she has never disciplined a charge for mistakes made by the employees under them. Cobbs did testify that she removed one charge nurse from her duties as charge because the charge could not keep up with her own work and could not learn to use the computer properly. Cobbs uses peer review in evaluating her employees, with at least two employees, including the employee's charge nurse, filling out a peer review on their co-worker before issuing her evaluation. When employees are interviewing, Cobbs testified that she will take the applicant around the unit to let the staff meet them and then she might ask the staff what they thought.

Cobbs testified that her charge nurses cannot discipline employees, but can provide her information if there is an issue with an employee. The charge nurses who have provided information about other employees to Cobbs, often don't provide her a recommendation as to what they feel is appropriate action. In fact, Cobb testified that she would expect all of her employees not only to raise

concerns they had with other employees with their charge nurse, but would also want the employee to raise those issues with her so that she could have the "real" information.

4. Cardiac Telemetry and ICU

Teresa Stevens is the Director over Cardiac Telemetry and ICU. Stevens serves over a department containing approximately 71 employees, 46 of whom are registered nurses. The remainder of the staff is comprised of certified nurses assistants and unit secretaries. The Employer believes that 6 of the 21 registered nurses who serve as charge nurses in ICU are supervisors under the Act. Those nurses are Kelly Raes, Patrick Harding, Stephanie Lainson, Sally Payne, Diana Dollen, and Laura Fox, all of whom worked in a charge capacity at least 16 hours per week over the 13 weeks preceding the hearing. The Employer further believes that 5 of the 24 registered nurses who serve as charge nurses in ICU are supervisors under the Act. Those nurses are Deborah Cline, Cathryne Harvey, Thomas Houvenagle, Sharon Kearney, and Judith Malloy, all of whom worked in a charge capacity at least 16 hours per week over the 13 weeks preceding the hearing. While, the department employs 71 employees, they are not on duty concurrently, but rather rotate through Psychiatric Services on the various shifts. On any given shift that Stevens works, she supervises 8 to 10 staff nurses, 2 charge nurses, 3-5 certified nurses assistants, and 1 unit secretary. While on call, during Cobbs' off hours, the house supervisor would supervise 6-7 staff nurses, 2 charge nurses, and 1 unit secretary in ICU and Telemetry.

Telemetry and ICU are 28 and 13 bed units respectively. Staff in the Telemetry and ICU work 12 hour shifts from 7 a.m. to 7 p.m. and 7 p.m. to 7 p.m.. The number of staff required for both units is dictated by the Employer's matrices. The charge nurse takes a full share of patients in ICU, but generally does not take patients in Telemetry. The evidence supports that charge nurses in Telemetry to not take patients for several reasons: they are responsible for using the Employer's computerized system for patient bed assignments; they help with patient admission; they handle all dismissal orders and transfer orders; and they contact other hospitals or nursing homes where that patient is being

transferred upon discharge. Additionally, the telemetry charge nurses handle statistical and data collection for the unit director, including a daily worksheet which is updated every four hours with patient information. Finally, the evidence shows that in Telemetry there is a central station with monitors for all 28 beds. Patients in telemetry are on cardiac or pulmonary monitors and this central station is where the charge nurse sits and monitors the central station. This station cannot be left unattended.

In Telemetry, the charge nurses assign nurses and certified nurses assistants to patients for the next shift. Nurses are assigned to patients in geographic blocks with the number of nurses to the number of patients being determined by the Employer's matrix. Unit Director Stevens testified that there would be little need to reassign employees to different patients in telemetry during a shift unless many nurses were floating into the unit, and then patient acuity might be taken into account. There was no testimony as to how frequently this happens.

In deciding which patients are going to be assigned to a particular nurse in ICU, the evidence from Unit Director Stevens and Charge Nurse Sally Payne supports that assignment decisions are made during report and are made in a collegial or collaborative fashion. The only time the acuity of the patient is considered in patient assignment is when someone is floated in from an outside unit, at that point the nurses in report, with the charge leading the discussion, will determine which of the patients the float nurses will be assigned. There is no evidence in the record as to how frequently less qualified nurses might be floated into the ICU. If employees float to ICU, the charge nurse might have to consider patient acuity in assigning the nurse, but the decision of who would be assigned to that floating nurse would be decided in conjunction with other staff nurses and by asking the nurse floating into the unit which patients they felt most comfortable with. There was no testimony as to how frequently nurses float into ICU.

If the matrix dictates that an employee should be sent home, it is the nursing services office that determines if a nurse will be sent home for low patient census. If a staff member needs to be sent

home, the charge nurse will solicit volunteers, and if no volunteers, the charge nurse uses the unit's contractual rotational on call list to send the employee home who has the fewest on call hours. If the units are understaffed during a shift, the charge nurse can call nursing services to see if there is any available help, but cannot call staff directly. In ICU, if nursing services could not send an employee when needed, Charge Nurse Sally Payne testified that she would ask for volunteers to take the patient, and if there were no volunteers would take the patient herself.

Stevens testified that a charge nurse can be held accountable for her charge duties. Stevens testified that in such a circumstance she would discuss the issue with the employee, but gave no testimony that this has happened, or that any discipline could result.

5. The Birthing Center

Sandy Bertelsen is the Director over the Birthing Center. Bertelsen serves over a department containing approximately 30 employees, 18 of whom are registered nurses. The remainder of the staff is comprised of certified nurses assistants and a birth registrar. The Employer employs distinctive types of nurses in the Birthing Center, labor and delivery nurses and mom/baby nurses. The work of the labor/delivery nurses is very specialized, and as such, mom/baby nurses and float or options nurses do not substitute for them. However, both labor/delivery, mom/baby, and float nurses can perform work with post partum mothers, work in the nursery and assist with GYN surgery. The Employer believes that 4 of its 18 registered nurses who serve as charge nurses are supervisors under the Act. Those nurses are Katie Comley, Patti Guill, Danielle Michels, and Sandra Stiles-Schultz, all of whom worked in a charge capacity at least 16 hours per week over the 13 weeks preceding the hearing. While, the department employs 32 employees, they are not on duty concurrently, but rather rotate through the Birthing Center on the various shifts. On any given shift that Bertelsen works, she supervises 3 staff nurses, 1 charge nurse, and a birth registrar. While on call, during Bertelsen's off hours, the house supervisor supervises 2 staff nurses, and 1 charge nurse in the Birthing Center.

The Birthing Center is comprised of 7 delivery rooms, 2 observation rooms, and 5 surgery rooms. Staff in the Birthing Center work 12 hour shifts from 7 a.m. to 7 p.m. and from 7 p.m. to 7 a.m.. The number of staff required in the Birthing Center is dictated by AWHONN, which is a staffing guideline established by a professional organization for obstetrical nurses. The matrix requires one nurse for each patient in labor and one nurse for four mom/baby "sets." Unit Director Bertelsen testified that her charge nurses take a full share of patients, and it is possible that because of their skill level they may take more patients than other staff nurses.

In deciding which patients are going to be assigned to a particular nurse, charge nurses in the Birthing Center make assignments for the oncoming shift based on the number of patients and the staff scheduled for the next day based on the matrix. Charge Nurse Comely testified that the number of nurses on any given shift is dictated by the matrix for the given number of patients on the floor. When Comely makes assignments for the next day she merely places the names of the nurses with the room numbers of the patients to equalize assignments.

Assignments during the day are based on equalizing the work load, and absent a request by a patient for a particular nurse, nurses are assigned based on who is working on that shift and has the fewest patients. If the number of nurses is unequal the charge nurse would determine who got the extra patient. The charge nurse might be required to reassign nurses during the course of the shift based on either the request of a patient or staff member, or due to an incoming labor patient. As stated above, the matrix in the birthing center requires that a laboring mother have one-on-one nursing care. As such, if a labor nurse is assisting a patient in another area, she may have to be pulled to be placed with the labor patient and the patient she was working with would not to be reassigned to another nurse. Additionally, if there is only one labor nurse on shift and another labor patient arrives at the hospital, the charge nurse would need to staff that patient with a labor/delivery nurse pursuant to the matrix. Because only labor nurses can assist labor patients, the charge nurse cannot use the house supervisor in nursing services to assist with additional staff. Instead, the charge nurse uses the list of

staff labor/delivery nurses and starts calling for volunteers, trying to avoid those that are scheduled to work the next day, and sometimes focusing on those labor nurses who she thinks might be more willing to come in to assist. The charge nurse cannot dictate that an employee come to work.

If the matrix determines that the unit is understaffed for mom/baby nurses, the charge nurse would first call any staff that nursing services placed on call due to low census under the collective-bargaining agreement, and then would call the house supervisor to see if there is a float nurse available. If a float nurse felt uncomfortable working with newborns, the charge nurse could assign her to a different task.

If the matrix dictates that an employee should be sent home, the charge nurse uses the unit's contractual rotational on call list to determine whom that would be.

Unit Director Bertelsen solicits the input of all of her staff in evaluating her employees.

6. Outpatient Surgery and Sterile Processing

Marsha Joens is the Director over Outpatient Surgery and Sterile Processing. At the time of the hearing, Joens supervised 33 employees in Outpatient and Sterile Processing, 14 of whom are registered nurses. [11] The remainder of the staff in these two units is comprised of certified nurses assistants, licensed practical nurses, unit secretaries, and receptionists. The Employer contends that 6 of the 14 registered nurses perform regular and substantial supervisory duties. Those nurses are Janel Allen and Luanne Depew in out-patient post recovery; Katherine Grote and Mary McKern in outpatient pre-op; Cynthia Watson in endoscopy; and Tammy Busse in Sterile Processing, all of whom worked in a charge capacity at least 16 hours per week over the 13 weeks preceding the hearing. All of the charge nurses the Employer contends are supervisors take an equal number of patients, if slightly less number of patients than the other registered nurses.

[11] The Employer claims that Joens directly supervises 74 employees. However, 41 of those employees are directly supervised by Surgery Manager Carol Deitchler, who serves under Joens.

In out-patient pre-op, Grote and McKern arrive for work at 5:30 a.m. to 6:00 a.m., depending on the time the physicians have scheduled procedures. Pre-op nurses assess and prepare patients prior to their procedures. Pre-op nurses only take care of one patient at a time, and when finished with that patient move onto the next patient. Employees in pre-op generally work an 8 hour day. Grote and McKern work half of their hours in a charge capacity. Working with Grote or McKern are generally 5 to 6 registered nurses, 2 licensed practical nurses, two certified nurses assistants, a unit secretary and a receptionist. Grote and McKern fill out assignment sheets for the following day referencing the time of the patient procedures, and then the times that employees will report to work based on the procedures scheduled times. Other than testimony that the times employees arrive is based on the scheduled time of the procedures, which is dictated by the physician, there is no evidence of how Grote and McKern determine the times that employees will appear for work when they fill out the assignment sheets. As to assigning nurses to particular patients during the shift, Joens testified that the nurses in pre-op would merely ask an available nurse to take a patient and get them ready for the procedure. Joens further testified that the charge nurse in pre-op would work with the staff to make sure that there was an equitable assignment of work and that the patients were taken care of quickly, with no lag time. Joens admitted that all the nurses are qualified to handle any of the work in the department.

In out-patient post recovery, Allen and Depew work from 2 p.m. until all of the patients leave, generally working an 8 hour day. Allen and Depew each work half of their time as charge nurses. Post recovery nurses can handle more than one patient at a time. On most shifts there are 4 to 5 registered nurses, on occasion a licensed practical nurse, 2 certified nurses assistants, a unit secretary and one receptionist. Allen and Depew take an equal number of patients to those taken by other registered nurses. Allen and Depew do not fill out assignment sheets because nurses are assigned to patients on a rotational basis.

In Endoscopy, Watson works an 8 hour shift starting anywhere from 6 a.m. to 8:30 a.m. depending on when the surgeon schedules the procedures. The assignments in endoscopy are standardized, with one nurse assessing patients pre-procedure, two nurses present during the procedure, and one nurse post procedure.

The sterile processing department disinfects, cleans, assembles and sterilizes the instruments needed for surgery and also for certain other areas in the hospital. Tammy Busse works half of her hours as a charge nurse in sterile processing. The other half of Busse's hours are spent as a staff nurse in the main surgery unit. When serving as a charge nurse, Busse works with six sterile processing technicians. The sterile processing department doesn't have any direct patient care responsibilities. Busse does not fill out an assignment form for the sterile processing technicians. Busse's Unit Director Marsha Joens testified that Busse does not use an assignment form because the technicians have standard shifts and duties. The only other evidence presented concerning Busse's duties related to the technicians was conclusory testimony that she can assign the technicians to lunch times.

Director Joens testified that all nurses in the Outpatient Department are qualified to perform any and all of the work they are assigned. Joens then testified, based on a leading question, and without any detail or example that charge nurses can assign employees to patients and tasks using the skills of the nurses and the acuity of the patients.

Joens further testified that charge nurses sometimes sit in on interviews, and may have voiced a similar opinion as to the applicant, but it is her decision as to who to hire.

Without example or explanation, Joens testified that charge nurses would be counseled or mentored if they were having trouble operating as a charge nurse. The record revealed no evidence of discipline of any charge nurse based on the conduct or performance of others.

D. Options Nurses

The Employer utilizes options nurses, who appear in common vernacular to be PRN nurses. These nurses perform the same work as that performed by unit nurses, including working on the

Ortho/Neuro unit, Medical/Surgical unit, ICU unit, Cardiac Telemetry unit, the Birthing Center, the Behavioral Health unit, Outpatient Surgical unit, the Emergency Room, and in the Personnel Pool. Options nurses may float from department to department without a regular assignment, or they may be regularly assigned to a department, but float to other departments as needed. These nurses were never included in the historical unit represented by the INA. The Employer does not guarantee the options nurses hours, but in order to be employed as an options nurse, the individual must agree to work a certain number of hours in one of the three levels of the Employer's Options Program. Level one of the Options Program requires a commitment of at least 24 hours per month of which 16 hours must be weekend coverage.. Level two of the program mandates that the registered nurse work at least 48 hours per month - two 12 hour shifts a week on nights. Finally, level three requires at least 72 hours of work - three 12 hour night shifts a week, with 48 of these hours on weekends. The amount of pay for the options nurse increases the higher the hours committed. Options employees receive no benefits from the Employer, but are subject to the same policies as other hospital employees, including the attendance policy.

E. Various Other RN Positions

1. Certified Lactation Consultant

Rita Madden is employed by the Employer as a certified lactation consultant from an office in the Birthing Center. While the position must be held by a registered nurse, Madden's position has historically been excluded from the unit defined in the collective-bargaining agreement between INA and the Employer. Madden's immediate supervisor is Sandra Bertelsen who also supervises the Birthing Center's 18 registered nurses who have traditionally been covered by the collective-bargaining agreement. The lactation consultant assists patients in the Birthing Center. If new mothers are having breastfeeding issues, the other registered nurses working in the Birthing Center will communicate those issues directly with Madden, who will then work with the patients. Madden also gives breastfeeding classes to mothers who have already been discharged from the hospital. Madden is

paid hourly. Madden receives the same hospital benefits and is subject to the same hospital personnel policies as those registered nurses in the petitioned for unit. Madden also uses the same dining and locker facilities used by other registered nurses.

2. Wound-Ostomy-Continence Registered Nurse

Linda Ellis is employed by the Employer as a wound-ostomy-continence registered nurse. While the position must be held by a registered nurse, Ellis' position has historically been excluded from the unit defined in the collective-bargaining agreement between INA and the Employer. Madden's immediate supervisor is Becky Henkel, Director of Nursing Services, who also supervises the Personnel or Float Pool registered nurses who the parties stipulated have traditionally been covered by the collective-bargaining agreement.. The wound-ostomy-continence registered nurse specializes in wound care and assists with dressings and wound assessment mostly in the inpatient units, but also in the wound care clinic. Ellis has regular contact with registered nurses in the petitioned for unit.

3. Breast Health Center Coordinator

Tammy Johnson is employed by the Employer as a breast health center coordinator. While the position must be held by a registered nurse, Johnson's position has historically been excluded from the unit defined in the collective-bargaining agreement between INA and the Employer. Johnson's immediate supervisor is Michelle Kaufman, who the parties stipulated is excluded from the petitioned for unit. The Breast Health Center is located on the hospital's main campus near the Wound Clinic. The breast health center coordinator assists patients with breast cancer in navigating radiology oncology and medical chemotherapy from the examination rooms in the clinic, although she also may have contacts with petitioned for registered nurses when breast cancer patients are inpatients. Johnson receives the same hospital benefits and is subject to the same hospital personnel policies as the registered nurses in the petitioned for unit. Johnson also uses the same dining and locker facilities used by other registered nurses.

4. Registered Nurse/Patient Care Coordinator

Barbara Kricsfeld is employed by the Employer as a registered nurse/ patient care coordinator. While the position must be held by a registered nurse, Kricsfeld's position has historically been excluded from the unit defined in the collective-bargaining agreement between INA and the Employer. Kricsfeld's immediate supervisor is Michelle Kaufman, who the parties stipulated is excluded from the petitioned for unit. Kricsfeld works in the main hospital building. Like the breast health center coordinator, the registered nurse/patient care coordinator assists patients with cancer undergoing radiology oncology. Kricsfeld has contact with other nurses in the petitioned for unit. Kricsfeld receives the same hospital benefits and is subject to the same hospital personnel policies as the registered nurses in the petitioned for unit. Kricsfeld also uses the same dining and locker facilities used by other registered nurses.

5. Wound Care Case Managers

Kathleen McGinnis and Jerilyn Smith are employed by the Employer as wound care case managers. While the position must be held by a registered nurse, wound care case managers have historically been excluded from the unit defined in the collective-bargaining agreement between INA and the Employer. McGinnis and Smith's immediate supervisor is John Meyer, who the parties stipulated is excluded from the petitioned for unit because he is not an employee of the Employer. The wound care case managers assess, measure and stage wounds and provide dressing changes from an outpatient Wound Clinic located on the hospital's main campus. McGinnis and Smith have contact with other nurses in the petitioned for unit. McGinnis and Smith receive the same hospital benefits and are subject to the same hospital personnel policies as the registered nurses in the petitioned for unit. McGinnis and Smith also use the same dining and locker facilities used by other registered nurses.

6. Patient Service Coordinators

Mary Christensen and Debra Coleman are employed by the Employer as patient service coordinators. Patient service coordinators have historically been excluded from the unit defined in the

collective-bargaining unit between INA and the Employer. The Employer does not require that patient service coordinators be registered nurses. The position can be held by either a registered nurse or a licensed practical nurse. However, both Christensen and Coleman are registered nurses. The patient service coordinator position is supervised by Donna Hubbell, Vice President of Quality & Patient Safety. Hubbell supervises no other registered nurses in the petitioned for unit, other than the pre-admission registered nurse, who the Petitioner agreed on brief, shared a sufficient community of interest to be included in the unit. The patient service coordinators are housed in an office near the outpatient surgery unit and have telephone contact with patients who are scheduled for outpatient surgery or endoscopy. They work with physicians and other departments in the hospital to schedule necessary lab tests and collect the results prior to the procedure. Christensen and Coleman receive the same hospital benefits and are subject to the same hospital personnel policies as the registered nurses in the petitioned for unit. Christensen and Coleman also use the same dining and locker facilities used by other registered nurses.

7. Pre-Admission Registered Nurse

Pamela Leinen and Ruth Plambeck are employed by the Employer as pre-admission registered nurses. While the Employer requires that the position be held by a registered nurse, pre-admission registered nurses have historically been excluded from the unit defined in the collective-bargaining agreement between INA and the Employer. The pre-admission registered nurse position is supervised by Donna Hubbell, Vice President of Quality & Patient Safety. The pre-admission registered nurses work in the same area as the patient service coordinators and are responsible for assessing the patients' health status prior to admission, analyzing the information gained in that assessment in conjunction with lab test results, and then communicating with patients and staff to make sure that all issues are covered when the patient arrives at the hospital for their procedure or outpatient surgery. Pamela Leinen and Ruth Plambeck receive the same hospital benefits and are subject to the same hospital

personnel policies as the registered nurses in the petitioned for unit. Pamela Leinen and Ruth Plambeck also use the same dining and locker facilities used by other registered nurses.

8. Employee Health Nurse

Karen Schaefer-Stein is employed by the Employer as an employee health nurse. Until the Summer of 2008, Schaefer-Stein worked for the Employer in the capacity of Vice-President of Patient Services, the position now held by Helget. Employee health nurses have historically been excluded from the unit defined in the collective-bargaining agreement between INA and the Employer. The Employer does not require that employee health nurses be registered nurses. The position can be held by either a registered nurse or a licensed practical nurse. However, Schaefer-Stein is a registered nurse. The employee health nurse position is supervised by Donna Wellwood, the Employee Health Coordinator, who the parties stipulated is a statutory supervisor. Wellwood supervises no other registered nurses in the petitioned for unit. The employee health nurse performs her work from an office in the Human Resources area of the hospital. Record evidence elicited from Vice President Helget supports that the Employer views Wellwood as the "full time" employee health nurse. The "full-time" employee health nurse is responsible for pre-employment physicals, screenings and immunizations; employee annual physicals, flu shots and other immunizations; and assessing employee injuries. Vice President Helget testified that Schaefer-Stein's main function as the employee health nurse is to serve as relief for the Employee Health Coordinator, who is a statutory supervisor. Helget further testified that Schaefer-Stein, as the employee health nurse, may also be called on to work during flu season to administer flu shots to employees and be called upon at other times of year when additional hours in employee health may be needed. Schaefer-Stein receives the same hospital benefits and is subject to the same hospital personnel policies as the registered nurses in the petitioned for unit. Schaefer-Stein also uses the same dining and locker facilities used by other registered nurses.

9. Assistant Coordinator/Family Health

Maureen Murray is employed by the Employer as the assistant coordinator/family health. Assistant coordinators family/health have historically been excluded from the unit defined in the collective-bargaining agreement between INA and the Employer. The Employer does not require that assistant coordinator/family health be held by a registered nurse. In fact, the position can be held by a registered nurse, a licensed practical nurse, or a medical assistant. However, Maureen Murray is a registered nurse. The assistant coordinator/family health position is supervised by Jean Armstrong, Family Resource Coordinator, who the parties stipulated is a statutory supervisor. Armstrong supervises no other registered nurses in the petitioned for unit. Armstrong and Murray perform their duties from the Family Resource Center, which is located on the first floor of the hospital, near the cafeteria. The Family Resource Center works with patients and patients' families to provide information and health education. The Center also holds quarterly community health fairs on various topics. Vice President Helget testified that Murray only works at the Family Resource Center as relief for Supervisor Armstrong and that is why Murray had no hours in the last 13 weeks before the hearing because Armstrong had not been absent. Murray receives the same hospital benefits and is subject to the same hospital personnel policies as the registered nurses in the petitioned for unit. Murray also uses the same dining and locker facilities used by other registered nurses.

III. ANALYSIS

A. Timing of the RC Petition and Validity of Disclaimer

1. Timing of the Petition

The Employer first claims that the Representation Petition that was filed on October 13, 2010, at 8:40 a.m. in the Regional Office should be dismissed because at the time it was filed, the INA had yet to deliver a valid disclaimer to the Employer. The INA's first disclaimer was not handed to the Employer until about 10:00 a.m. on October 13, 2010, an hour and twenty minutes after it filed its

Petition to represent employees with the Regional Office. As such, according to the Employer, when the Petition was filed, the contract was still in effect and would act as a bar.

The Employer further argues that the October 13th INA disclaimer that was given to the Employer during the labor/management meeting was not a clear and unequivocal disclaimer because statements made by Ballantyne during the meeting indicating that the INA would continue its representation of employees through January 1, 2011, rendered the disclaimer unclear. The Employer acknowledges that the revised disclaimer it received on October 14 from Goeldner was arguably clear and unequivocal, but because the Petition had been on file for a day, without an effective disclaimer, the contract between the INA and the Employer was a bar and the Petition should be dismissed.

The Employer's arguments on this point are misplaced. The timing of the filing of a disclaimer in a representation proceeding often follows the filing of the representation case petition as is shown through both the Board's Representation Case Handling Manual and Board case law. The Board's Representation Case Handling Manual contemplates that a disclaimer is generally filed after the filing of a petition. As the manual explains, in an RC petition setting, after the RC petition is filed, if a disclaimer is filed by a union with certification or an outstanding collective-bargaining agreement it will operate to allow the certified or recognized union to avoid participation in the proceeding. See, NLRB Case Handling Manual II, Representation, Section 11120. The manual further explains that if the disclaimer is in writing and there is no inconsistent action, the union may thereafter be disregarded as a party and that an election agreement may be consummated without the participation or acquiescence of the disclaiming union. Finally, the manual states that if the disclaimer of interest is by a previously certified union, the Region's dismissal or approval of withdrawal of recognition should contain a revocation of the prior certification. Id. at Section 11122.

Similarly, in reviewing the Board's case law on the issue of disclaimers, while there is no case that addresses the issue of the timing of the disclaimer specifically, there are cases where the Board has approved a union's disclaimer that arose in situations where the disclaimer was filed after the petition

was filed. See, *Plough, Inc.*, 203 NLRB 121 (1973); *American Sunroof Corporation/Customcraft, Inc.*, 243 NLRB 1128 (1979). Even in those cases where the Board did not give effect to a union's attempts to disclaim during the term of the contract, the timing of the disclaimer, after the filing of the petition was of no import. See, *Mack Trucks, Inc.*, 209 NLRB 1103 (1974). The procedural timing of the filing of the disclaimer is not the issue; the issue is whether the disclaimer is invalid and, if so, whether the contract between the INA and the Employer operates as a bar to this petition, which will be addressed below.

Finally, and most importantly, it appears that under current Board law the petition is timely. Where the parties' contract is a four year agreement, it can only bar filing of a representation petition for three years. *General Cable Corp*., 139 NLRB 1123 (1962). Thus, in the instant case, the contract can only operate as a bar to the MNA's petition through March 9, 2011. As such, the petition would be timely if filed during the insulated period 120 to 90 days prior to the three year expiration of the agreement, which would be from November 10, 2010 through December 9, 2010. See, *Union Carbide Corp.*, 190 NLRB 191 (1971)(Where the contract is of unreasonable duration – more than three years – a petition is timely filed if filed during the insulated period before the expiration of the third year of the agreement.); *Trinity Lutheran Hospital*, 218 NLRB 199 (1975) (In health care cases, the petition must be filed not more than 120 days and not less than 90 days before the contract's expiration.). The petition in this case was filed on October 13, 2010, still one month premature of that insulated period. However, a petition filed prematurely will not be dismissed where a hearing is directed, despite the prematurity of the petition, in order to resolve doubts as to the effectiveness of the contract as a bar, and the decision issues on or after the beginning of the window period, or in the instant case, the 120th day preceding the expiration date of the contract. See, *Deluxe Metal Furniture Co.*, 121 NLRB 995, 999(1958); *Royal Crown Cola Bottling, Co.*, 150 NLRB 1624 (1964)(Board found it unnecessary to rule on the employer's contention that the contract was a bar and the petitioner's contention that the contracting union was defunct because, despite the fact that the petition was prematurely filed, the

decision issued after the beginning of the window period, and as such, the petition was considered timely filed and the contract was not a bar.); and *Maramount Corp*., 310 NLRB 508, 512 (1993). In the instant case, while the petition was filed prematurely, a hearing was directed to determine whether the INA's disclaimer was effective, or if, despite the disclaimer, the INA's contract operates as a bar to the MNA's petition. The decision and direction of election on this issue is being issued on November 22, 2010, which is clearly after the beginning of the insulated period which began on November 10. As such, the petition is timely; the contract does not operate as a bar; and the petition will not be dismissed. Additionally, because I have found the petition timely, the Employer's Motion to Dismiss the Petition is denied.

2. Validity of the Disclaimer

Despite my ruling that the petition filed by the MNA in the instant case is timely, I will briefly address the Employer's contention that the INA's disclaimer is invalid under the Board's reasoning in *Mack Trucks, Inc.*, 209 NLRB 1003 (1974), where a disclaimer by the incumbent union was held invalid and the current collective-bargaining agreement held to bar a rival union's petition because the unions had colluded in filing the petition to avoid the terms of a valid collective-bargaining agreement.

First, it is well settled that a contract does not bar an election when the contracting union has validly disclaimed interest in representing the employees covered by the agreement. To be effective, a disclaimer must be clear and unequivocal and made in good faith. *VFL Technology Corp.*, 332 NLRB 1443 (2000), citing *American Sunroof*, 243 NLRB 1128 (1979). In *VFL Technology Corp*., the Board held that a union's disclaimer was effective and removed the contract as a bar because the disclaimer was clear and unequivocal and there was no evidence that the disclaimer was a tactical maneuver, a sham, or made in bad faith in an effort to avoid the terms and conditions of the collective-bargaining agreement. [12]

[12] I find that the Employer's continued check-off and transmission of dues to the INA after the disclaimer does not operate to render the disclaimer ineffective. There is no evidence concerning the INA's actions related to receipt of the dues, and it

As in *VFL*, and unlike *Mack Trucks, Inc.*, there is no evidence that the INA's action in disclaiming interest in representing the Employer's employees was a tactical maneuver, a sham, or made in bad faith in an effort to avoid the terms of the Parties' collective-bargaining agreement. Rather, the evidence supports that the INA's disclaimer was based on its adamant refusal to affiliate with the NNU, despite the wishes of its Local 933; its inability and unwillingness to continue to represent employees in a collective-bargaining capacity given its financial restraints, which had been ongoing for several years; and its decision that it would no longer serve as a labor organization, but would rather, serve solely as a lobbying organization addressing issue of importance to nurses in Iowa. [13] I find that these reasons are not the type of collusion to avoid the terms of the collective bargaining agreement that must be shown in order to render an otherwise clear and unequivocal disclaimer invalid.[14]

B. Charge Nurses

Section 2(11) of the Act sets forth a three-part test for determining whether an individual is a supervisor. Pursuant to this test, employees are statutory supervisors if: (1) they hold the authority to engage in any one of the 12 supervisory functions listed in Section 2(11); (2) their exercise of such authority is not of a merely routine or clerical nature but requires the use of independent judgment; and (3) their authority is held in the interest of the employer. See *NLRB v. Kentucky River Community Care, Inc.,* 532 U.S. 706 (2001); *NLRB v. Health Care & Retirement Corp. of America,* 511 U.S. 571, 573-574 (1994). In applying this three part test, certain basic principles remain unaffected by the

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is clear that the only reason they are receiving the dues is because the Employer continues to transmit them, despite the clear and unequivocal waiver. A few arguably inconsistent post disclaimer actions do not negate the effectiveness of the disclaimer. See *VFL Technology Corporation*, 332 NLRB 1443, 1447 (2000)

[13] The INA's continued representation of employees at Mitchell County Hospital until those employees' contract expires in 2011 does not change the fact that the INA is transitioning out of serving in the capacity as a labor organization for nurses Iowa, and that this transition is nearly complete.

[14] Because I have found that the INA's disclaimer was clear and unequivocal, that the INA has not acted inconsistently with such disclaimer, and that the disclaimer was not a tactical maneuver, a sham or made in bad faith to avoid the terms of the collective-bargaining agreement, the Order Revoking Status of the Union that issued on October 20, 2010, was properly issued. As such, the Employer's Motion to Withdraw Regional Director Order Revoking Status of Union Dated October 20, 2010 is denied.

Board's recent decisions on supervisory status. First, the party alleging that an individual is a supervisor has the burden of proof. *NLRB v. Kentucky River Community Care, Inc.*, 532 U.S. 706, 712 (2001). Second, any lack of evidence in the record is construed against the party asserting supervisory status. *Elmhurst Extended Care Facilities, Inc.*, 329 NLRB 535, 536 fn. 8 (1999). Third, purely conclusary evidence is not sufficient to establish supervisory status. *Volair Contractors, Inc.*, 341 NLRB 673, 675 (2004); *Sears, Roebuck & Co*., 304 NLRB 193, 194 (1991). Fourth, policies and job descriptions alone do not suffice to show supervisory authority. *Training Scholl at Vineland*, 332 NLRB 1412, 1416 (2000). Finally, "the Board . . . exercise[s] caution 'not to construe supervisory status too broadly because the employee who is deemed a supervisor is denied rights which the Act is intended to protect.'" *Oakwood Healthcare, Inc.*, 348 NLRB at 688, citing *Chevron Shipping Co.*, 317 NLRB 379, 381 (1995).

The Board's *Oakwood* trilogy decisions clarified the circumstances in which it will find that individuals exercise sufficient discretion in performing two of the supervisory functions listed in Section 2(11) – assignment and responsible direction of work. In addition to defining critical terms, the Board concluded that assignment and responsible direction must have "a material effect on the employee's terms and conditions of employment" in order to confer supervisory status. *Oakwood Healthcare, Inc.*, 348 NLRB at 695.

In *Oakwood*, the Board construed the term "assign" as "the act of designating an employee to a place (such as a location, department or wing), appointing an employee to a time (such as a shift or overtime period), or giving significant overall duties, i.e., tasks, to an employee." *Id.* at 689. To "assign," for purposes of Section 2(11), "refers to the charge nurse's designation of significant overall duties to an employee, not to the charge nurse's ad hoc instruction that the employee perform a discrete task." *Id*. Further, in *Oakwood* the Board found that in the health care setting "the term 'assign' encompasses the charge nurses' responsibility to assign nurses and aides to particular patients." *Id.* at 687. Noting that certain assignments are more difficult and demanding than others, the Board found

that the charge nurses' ability to assign employees to one or the other is of importance to the employees and management as well. The Board also indicated that:

> matching a patient's needs to the skills and special training of a particular nurse is among those factors critical to the employer's ability to successfully deliver health care services. *Id*. at 689.

In *Oakwood,* the Board noted that the phrase "responsibly to direct" was not meant to include minor supervisory functions performed by lead employees. The Board explained "responsible direction" as follows: "If a person on the shop floor has men under him, and if that person decides what job shall be undertaken next or who shall do it, that person is a supervisor, provided that the direction is both 'responsible'. . . and carried out with independent judgment." *Id.* at 691 (internal quotations omitted). "Responsible direction," in contrast to "assignment," can involve the delegation of discrete tasks as opposed to overall duties. *Id.* at 690-91. An individual will be found to have the authority to responsibly direct other employees only if the individual is *accountable* for the performance of the tasks by those employees. Accountability means that the employer has delegated to the putative supervisor the authority to direct the work and the authority to take corrective action if necessary, and the putative supervisor faces the prospect of adverse consequences if the employees under his or her command fail to perform their tasks correctly. *Id.* at 692.

Assignment or responsible direction will produce a finding of supervisory status only if the exercise of independent judgment is involved. Independent judgment will be found where the alleged supervisor acts free from the control of others, is required to form an opinion by discerning and comparing data, and makes a decision not dictated by circumstances or company policy. *Id.* at 693. Independent judgment requires that the decision "rise above the merely routine or clerical." *Id.*.

Where an individual is engaged a part of the time as a supervisor and the rest of the time as a unit employee, the legal standard for a supervisory determination is whether the individual spends a regular and substantial portion of her work time performing supervisory functions. Under the Board's

standard "regular" means according to a pattern or schedule, as opposed to sporadic substitution. The Board has not adopted a strict numerical definition of substantiality, but has found supervisory status where the individuals have served in a supervisory role for at least 10%-15% of their total work time. *Oakwood Healthcare, Inc.*, 348 NLRB at 698-700.[15]

In this case, the evidence fails to support that the charge nurses hire, transfer, suspend, lay off, recall, promote, discharge, reward, discipline, or adjust employee grievances, or effectively to recommend such action. Rather, the sole area of contention is whether charge nurses assign and/or responsibly direct employees, using independent judgment.

While the Employer contends that that charge nurses may effectively recommend such supervisory decisions such as hiring, imposition of discipline and employee evaluations, I find the evidence to this end unpersuasive. As outlined above, while there is some evidence that charge nurses may report situations that could lead to employee discipline, the record is more than replete that these actions on the part of charge nurses are merely reportorial in nature and that unit directors make their own decisions regarding any potential consequences of what they learned from their charge nurses. Additionally, most of the unit directors admitted that they expect all of their employees to report instances of misconduct. The Employer's evidence as it relates to effectively recommending discipline falls far short of that which would be required to prove supervisory status.

I further find that the testimony of the unit directors that charge nurses may have input into hiring decisions, have input into employee evaluations, and can assign lunches is not dispositive of their supervisor status. As to the input provided for hiring decisions and employee evaluations, the

[15] As mentioned in footnote 10 above, the Employer presented no evidence as to the 39 individuals who sometimes perform charge nurse duties, and who have volunteered and are attending the Employer's charge nurse training. As such, even if the 43 individuals identified in Employer Exhibit 9 that the Employer contends are charge nurses are in fact supervisors, the 39 additional individuals listed in Employer Exhibit 26, who are not contained on Employer Exhibit 9, have not been shown to perform regular and substantial supervisory duties and will be eligible to vote. Those individuals are Kristen Anderson, Justin Bond, Scott Brown, Jill Ferguson, Jenny Hughes, Angie Shanno, Gae Hilgenberg, Ellen Ruby, Trish Vermuele, Arthea Youngs, Terry Zimmerman, Shawna Ateberry, Jodi Croatt, April Blackbourn, Heidi Watts, Marie Fox, Mary Grote, Michelle Lainson, Jennifer Peck, Cheryle Rambo, Whitney Shadden, Kathy Vorthmann, Kathleen Carrigan, Anita Dargy, Kitty Eisenauer, Bonnie Hall, Kyle Kreger, Tomomi Reeson, Deb Simonin, Bev Stangl, Marilyn Fife, Carline Guyer, Jenner Nelson, Deedee Amdor, Mary Hildebrand, Lorrie Reddish, Ellen Bammer, Teri Kendall, and Mary Vogt.

vast preponderance of the evidence is that any staff personnel, irrespective of their job title/duties, may have casual input into hiring decisions and employee evaluations. In fact many of the unit directors testified that they use peer evaluations to complete evaluations on all of their employees. There is insufficient concrete evidence that any of the Employer's charge nurses have effectively recommended any hiring or evaluative decisions. As to assignment of lunch periods, again the lack of substantive evidence that such assignments are made with independent judgment, rather than being purely ministerial acts, dictate that such assignments cannot support a supervisory finding.

1. Assignment and Responsible Direction

The overall record evidence, as outlined above, shows that the daily assignment of patients by the charge nurses is not done with independent judgment, and the ministerial action of filling out a daily assignment sheet, does not change that fact. The overwhelming evidence establishes that in making daily staffing assignments, the charge nurses do not match the patient's acuity level with the skill level of the staff member. Rather as outlined in the fact section, charge nurses in the various departments assign staff based on equalizing the work load, with some charge nurses not even assigning staff to patients on their own shift, but rather assigning staff to the next shift. This next shift assignment structure is the norm the Birthing Center, Telemetry, Adult and Pediatric Med/Surg, and Ortho/Neuro. Assigning work to the oncoming shifts, where the skill levels of the staff are not fully known to the charge nurse making the assignments, is not indicative of assignment using independent judgment, and rather, would support that the assignment is clerical in nature, merely seeking to equalize the staffing and keep nurses in the same geographic area for efficiency's sake. This conclusion is supported by the record, and contradicts the otherwise conclusionary testimony that patient acuity and skill levels of the staff are used to assign patients. In other units such as ICU and Psychiatric Services the charge nurses work collaboratively to assign the work for their shifts, which undercuts the use of independent judgment by the charge nurse. In the outpatient unit, assignment of staff is based on the scheduling of the procedure by the physician, and work is then assigned with

equalization of work in mind, because all staff are equally qualified to perform work in their areas. Finally, in the Emergency Center staff is allocated using both a charge nurse and a triage nurse to assign staff to incoming patients on a rotational basis, with whoever is available being assigned to the next patient.

While the Employer's unit directors repeatedly testified that assignments made by charge nurses on their units were made with the acuity of the patients' condition and the skill of the nurses in mind, the vast majority of that testimony was made in response to leading questions and lacked substance, or explanation. For instance, while Unit Director Joens testified without detail that the acuity of the patients and the skills of the nurses were used in determining patient assignment, her more detailed testimony as to each category of nurse (pre-op, post-op, endoscopy, and sterile processing), as outlined above in the fact section, more than supports that such assignments were standardized and made without the use of independent judgment. Unit director Cobb did testify more specifically about her observation of the daily patient assignment in her unit, but even that testimony did not establish the supervisory status of her charge nurses. Unit Director Cobbs was recalled to testify after the testimony of Lisa Boells that daily assignments in Psychiatric Services were made collaboratively and were not based on specific assessment of the skills of the staff nurses and the acuity of the patients. While Cobbs testified that she observed her charge nurses using patient acuity and nurses skills to assign patients to various nurses, her explanation of how this was done supports that such assignments, while taking into account patient acuity, do not involve the independent judgment of the charge nurses, and supports instead, that decisions are actually made in a collaborative fashion with the nurses speaking up and stating which patients they want to work with on any given shift. While in each instance, the charge nurse may have the ultimate assignment decision, the totality of the evidence supports that the assignments are made with patient equalization as a goal, without the requisite use of independent judgment necessary to render these nurses ineligible for coverage under the Act.

As with the testimony related to the daily assignment of work, there was blanket testimony from the Employer's witnesses, again in response to mostly leading questions that that if the patient census falls, a charge nurse can ask employees to go home. This testimony, as set forth in the fact section above, is unpersuasive and does not support a supervisory finding. The Employer asserts that the charge nurses use independent judgment to send employees home when overstaffed and bring employees in when understaffed. However, the evidence shows that all departments have very detailed staffing matrices that guide how many staff members should be working in any given department. The patient census is updated every four hours based on information gathered by the charge nurses, and it is this information and the application of the matrices from each unit that determines when a unit is overstaffed or understaffed. When the staffing matrix establishes that a department is understaffed, the charge nurse will generally notify the nursing services office, who will then attempt to fill the void caused by the increase in the patient census by floating a nurse to that department, or using an options nurse. While some charge nurses may be allowed to phone staff directly to try to fill in for absences due to illness (the Emergency Center) or for increased patient load requiring additional staff under the matrices (the Birthing Center), the evidence supports that their decision to do so is based solely on the matrices, not independent judgment on their part. When allowed to call staff directly, the evidence establishes that the charge nurse uses a list provided by the Employer for this very purpose, and generally starts at top of the list and calls down the list until someone agrees to work the shift.

Similarly, the evidence establishes that when a department is overstaffed, as defined by the staffing matrices, the same general procedure is followed: before sending a staff member home to be on call under the collective-bargaining agreement, first nursing services will see if the staff member can be floated to another department. If that is not feasible, or the nursing service office does not have someone who has volunteered to go on call, the nursing services office will notify the charge nurse that an employee needs to go home. The charge nurse's action after this is merely ministerial, by first soliciting volunteers to go on call, and then by using the contractually agreed rotational on call list that

is maintained in each department. In sum, the charge nurses do not use their independent judgment to determine if a department is overstaffed or understaffed and make assignments accordingly. Instead, it is clear from the record that these determinations are dictated by the staffing matrices. In order to be supervisory, the assignment of employees must be exercised with independent judgment and involve a degree of discretion that rises above the "routine and clerical." At a minimum, to exercise independent judgment, the purported supervisor must act, or recommend action, free of the control of others and form an opinion or evaluation by discerning and comparing data. *Oakwood Healthcare, Inc*., 348 NLRB at 693. The Board has held that a judgment is not independent if it is dictated or controlled by detailed instructions, whether set forth in company policies or rules, the verbal instructions of a higher authority or in the provisions of a collective bargaining agreement. *Ibid*.

The Employer argues in brief that the charge nurses do use their discretion and judgment as to whether additional staffing is required outside of any established matrices or guidelines. This contention appears to come from the testimony of the Employer's unit directors and charge nurses, based by and large on leading questions by the Employer's counsel, that charge nurses can deviate from the matrices. There is little specific evidence or examples in the record to support this argument, and what evidence there is supports that deviation from the matrices is done only in emergency situations when the patient is in danger, or after permission from the unit director or house supervisor. I find that such testimony is not sufficient to establish they type of discretion and independent judgment to deviate from the Employer's policies that is contemplated by the Board to remove an individual from the protections of the Act.

There is very little evidence in the record concerning responsible direction of employees to perform discrete tasks, rather than the overall assignment of work. There is some testimony that a charge nurse might direct certified nurses assistants to perform an electrocardiogram, or to check patients vitals, or check on patients every fifteen minutes, or that the charge nurse might ask a nurse to handle pre-op for a patient in a particular room.

First, the type of evidence presented that charge nurses responsibly direct employees in the performance of discrete tasks does not support that such direction is with independent judgment. Assigning an aid to perform an electrocardiogram, or writing in a staff member's name on a daily assignment sheet to check the temperature and clean out the refrigerator, does not establish that such assignment was made with independent judgment, particularly where, at least as to the direction to perform an electrocardiogram, such direction is performed by all registered nurse, not just the charge nurse.

I further find no persuasive evidence in the record to indicate that charge nurses are "accountable" for enforcing the directions that they administer to employees. In that regard, the record revealed no evidence that charge nurses' have been disciplined or otherwise held accountable, based upon the performance of individuals they direct. The unit director's and Charge Nurse Ballantyne's testimony that a charge nurse could be "spoken with" to is not the type of accountability that would support responsible direction. The Board held in *Oakwood* that:

> the person directing and performing the oversight of the employee must be accountable for the performance of the task by the other such that some adverse consequence may befall the one providing the oversight if the tasks performed by the employee are not performed properly. *Oakwood Healthcare, Inc.,* 348 NLRB at 692.

While the Employer provided an instance of a charge nurse being disciplined by Unit Director Cobb for failure to perform adequately in the role of a charge nurse, the evidence supports that this discipline involved discipline based on the charge nurse's performance or conduct, not that of her subordinates. Additionally, Unit Director Schmid's testimony that a charge nurse could be disciplined for failing to perform three discrete charge nurse tasks is in the same vein. Such discipline would be the result of failure of the charge nurse to perform her own duties, not discipline for subordinates failing to perform theirs. Such evidence falls far short of meeting the standard for accountability laid

out in *Oakwood*. Accordingly, I find that charge nurses are not held accountable for the performance of tasks by subordinate employees and therefore, that charge nurses did not direct work "responsibly."

While acknowledging the Employer's argument that the number of employees per supervisor is high if the charge nurses are not found to be supervisors, I find that argument unpersuasive in these circumstances. The Employer has not ceded supervisory authority to its charge nurses in the fundamental areas of hiring, firing, discipline, evaluation, layoff, or reward. All of these functions remain solidly with the Employer's unit directors. Additionally, through the use of their matrices, the nursing services office, and the dictates of the collective-bargaining agreement, the Employer has emasculated any authority the charge nurses may have had concerning assignment of work with independent judgment. In particular, the nursing services department, with its house supervisors, operates as a separate level of supervision over the charge nurses and handles the vast majority of the staffing adjustments required during all shifts, staffing adjustments which the Employer contends most heavily support a finding of supervisory status. As such, the Employer's high level of policy, contractual rules, and standardization allows for higher supervisory ratios.

Additionally, while the Employer points to the high supervisory ratio, this is not a situation where the unit director is tasked with supervising all of the employees under his direction at the same time. Instead, the unit directors direct supervision of unit employees on a day to day basis is limited to only those employees who are working during that time, a much lower number than all of the employees working in the department. I further find that the fact that during off hours the facility is covered by only a house supervisor is not dispositive that the off shift charge nurses are supervisors. There is supervision on staff at all hours. The unit directors are concededly on call. Additionally, the nursing services office, with its house supervisors, which handles most staffing issues, is staffed at all hours.

Finally, it is not unprecedented for the Employer to operate departments with high employee to supervisor ratios without the use of charge nurses. For instance, in surgery where the Employer does

not utilize charge nurses, surgery manager Carol Deitchler directly supervises 41 employees, more than many of the units the Employer claims could not operate without in intermediate level of supervision, given the supervisory to employee ratio.

In conclusion, I find that the Employer's charge nurses are not supervisors under the Act and will be in included in the unit found appropriate.

C. Options Nurses

The most common eligibility formula for determining the eligibility of irregular part-time employees is the formula found in *Davison-Paxon*, 185 NLRB 21, 24 (1970), under which employees who average 4 hours per week for the calendar quarter preceding the election eligibility date are eligible to vote. In the health care industry, the most commonly used standard is also the *Davison-Paxon* formula. *Sisters of Mercy*, 298 NLRB 483 (1990); *Beverly Manor Nursing Home*, 310 NLRB 538 (1993).

As cited above, the evidence presented concerning the options nurses supports that they have an overwhelming community of interest with other registered nurses undisputedly in the unit. Record evidence shows that options nurses work in the emergency room, in the ortho/neuro unit, in adult and pediatric medical/surgical services, in the behavioral health unit, in cardiac telemetry, in ICU, and in outpatient surgery, and the personnel pool[16] alongside nurses who are concededly in the appropriate unit. Additionally, when working in those areas options nurses perform the same functions as other registered nurses. While they do not receive the same benefits as other staff nurses, they are subject to the same rules and regulations.

While there seemed to be dispute as to the inclusion of the options nurses at the hearing, it appears on briefing that both parties agree that the appropriate unit should include the options nurses.

[16] The parties stipulated at the hearing that the Employer's float pool or personnel pool nurses who both regularly float to different departments and who are pulled from their regular reporting floor to float are included in the appropriate unit and were included in the historical unit represented by the INA. These personnel pool or float nurses are different than the options nurses, over which there appeared to be a dispute at the hearing.

[17] The parties further agree in their briefs that the formula for determining the eligibility of the options nurse is the *Davison-Paxon* formula. As such, I find that the options nurses who worked an average of 4 hours per week during the calendar quarter immediately preceding the date of issuance of this Decision and Direction of Election will be allowed to vote.

D. Various Other RN Positions

1. While refusing to take a position on their inclusion or exclusion from the petitioned for unit, the Employer presented evidence that the certified lactation consultant, the wound-ostomy-continence registered nurse, the breast health center coordinator, the wound care case managers, the registered nurse/patient care coordinator, and the pre-admission registered nurse share a community of interest with those registered nurses who the parties concede are appropriately in the unit. In its brief, the Petitioner agrees that the above-listed job classifications should be included in the petitioned for unit. As such, because the evidence shows that the positions of certified lactation consultant, the wound-ostomy-continence registered nurse, the breast health center coordinator, the wound care case manager, the registered nurse/patient care coordinator, and the pre-admission registered nurse share a community of interest with those registered nurses in the petitioned for unit, I will include them in the appropriate unit.

2. Patient Service Coordinator, Employee Health Nurse, and Assistant Coordinator/Family Health

[17] The Petitioner argues that Heidi Watts, who is listed on Employer's Ex. 15 as an options nurse in the personnel pool, should be excluded from the unit because she regularly serves in the position of house supervisor, a position that both parties agree should be excluded from the unit. I find that the evidence does not support that Watts is a supervisor and if she has sufficient hours of work at the time the Davison-Paxon formula is applied to the Employer's options nurses, she will be allowed to vote. There was evidence that Watts has occasionally filled in for a house supervisor due to a medical event of one of the house supervisors. However, there is no evidence presented as to how long Watts has been filling in for the house supervisor, who appears to have an absence of one shift a week, or whether other individuals other than Watts also fill in for this absent house supervisor. The evidence further supports that Watt's substitution as house supervisor is infrequent, where the position of house supervisor is filled almost 100 percent of the time with a full time house supervisor. This Petitioner has not met its burden to establish that Watts performs house supervisory duties regularly and substantially, which would warrant her exclusion from the unit as a statutory supervisor.

There is some evidence that Employee Health Nurse Schaefer-Stein and Assistant Coordinator/Family Health Murray should be excluded from the unit as supervisors because they regularly and substantially substitute for Donna Wellwood and Jean Armstrong, who the parties stipulated are statutory supervisors. In fact, here the evidence supports that the jobs of the Employee Health Nurse and Assistant Coordinator/Family Health are meant to be relief positions for the "full time" employees in those departments, Donna Wellwood and Jean Armstrong.

Regular and substantial service as a substitute supervisor can confer supervisory status. *Aladdin Hotel,* 270 NLRB 838, 840 (1984); *Honda of San Diego*, 254 NLRB 1248 (1981). Additionally, where an employee completely takes over the supervisory duties of another, he is regarded as a supervisor under the Act. *Birmingham Fabricating Co.,* 140 NLRB 640 (1963); *Illinois Power Co.,* 155 NLRB 1097 (1965). However, the Board has long recognized that, regardless of how frequently an employee substitutes for a supervisor, if he or she does not exercise the supervisor's statutory authority while acting as a substitute, then he or she is not a statutory supervisor. *See, e.g., Passavant Health Center, 284 NLRB 877, 892 (1987); Boston Store,* 221 NLRB 1126, 1127 (1975) In this case, because there is no evidence in the record that Schaefer-Stein and Murray possess any statutory supervisory authority when they substitute for the regular supervisors, such substitution does not confer supervisory status.

The next question is whether the fact that the Employer does not require that the positions of patient service coordinator, employee health nurse, and assistant coordinator/family health be held by a registered nurse should exclude them from the unit. I believe that it should result in their exclusion.

In *Salem Hospitals*, 333 NLRB 560 (2001), the Board dealt with the issue of whether the position of utilization review case manager, which was held by both registered nurses and social workers should be included or excluded from the unit. The Regional Director had included the position, but only for those individuals who held the position as registered nurses. The Board reversed the Regional Director and held that the determining factor in whether a registered nurse should be

included in a registered nurse unit is whether the employer requires or effectively requires registered nurse licensure to hold the position. *Id*. at 560.

In the instant case, the evidence supports that the Employer does not require registered nurse licensure for the disputed positions. While all of the positions are currently held by registered nurses, the Employer's Vice President Helget testified that none of the positions required that the employee be a registered nurse. As to the positions of patient service coordinator and employee health nurse, Helget testified that these positions could be held by licensed practical nurses as well as registered nurses. Helget further testified that the position of assistant coordinator/family health could be filled with a registered nurse, a licensed practical nurse, or a medical assistant. Other than the fact that the positions are currently all held by registered nurses, the Employer presented no evidence that it "effectively required" registered nurse licensure to hold the positions and the Employer's job descriptions clearly allow for non-registered nurses to hold these positions. Based on the above analysis, I find that the positions of patient service coordinator, employee health nurse, and assistant coordinator/family health do not share a community of interest with the other registered nurses in the unit and will be excluded.

IV. DIRECTION OF ELECTION

An election by secret ballot shall be conducted by the undersigned, among the employees in the unit found appropriate at the time and place set forth in the notice of election to be issued subsequently, subject to the Board's Rules and Regulations. Eligible to vote are those in the unit who were employed during the payroll period ending immediately preceding the date of this Decision, including Options RN's who have worked an average of 4 hours per week during the calendar quarter immediately preceding the date of issuance of this Decision and Direction of Election, and employees who did not work during that period because they were ill, on vacation, or temporarily laid off. Employees engaged in any economic strike, who have retained their status as strikers and who have not been permanently replaced are also eligible to vote. In addition, in an economic strike which

commenced less than 12 months before the election date, employees engaged in such strike who have retained their status as strikers but who have been permanently replaced, as well as their replacements, are eligible to vote. Those in the military services of the United States who are employed in the unit may vote if they appear in person at the polls. Ineligible to vote are employees who have quit or been discharged for cause since the designated payroll period, employees engaged in a strike who have been discharged for cause since the commencement thereof and who have not been rehired or reinstated before the election date, and employees engaged in an economic strike which commenced more than 12 months before the election date and who have been permanently replaced. Those eligible shall vote whether or not they desire to be represented for collective bargaining purposes by:

MINNESOTA NURSES ASSOCIATION, affiliated with NATIONAL NURSES UNITED / AFL-CIO.

V. ELECTION NOTICES

Please be advised that the Board has adopted a rule requiring that election notices be posted by the Employer at least three working days prior to an election. If the Employer has not received the notice of election at least five working days prior to the election date, please contact the Board Agent assigned to the case or the election clerk.

A party shall be estopped from objecting to the non-posting of notices if it is responsible for the non-posting. An employer shall be deemed to have received copies of the election notices unless it notifies the Regional Office at least five working days prior to 12:01 a.m. of the day of the election that it has not received the notices. *Club Demonstration Services*, 317 NLRB 349 (1995). Failure of the Employer to comply with these posting rules shall be grounds for setting aside the election whenever proper objections are filed.

VI. LIST OF VOTERS

In order to insure that all eligible voters may have the opportunity to be informed of the issues in the exercise of their statutory right to vote, all parties to the election should have access to a list of voters and their addresses which may be used to communicate with them. *Excelsior Underwear, Inc*., 156 NLRB 1236 (1966); *NLRB. v. Wyman-Gordon Company,* 394 U.S. 759 (1969). Accordingly, it is directed that two copies of an election eligibility list, containing the full names and addresses of all the eligible voters, shall be filed by the Employer with the Regional Director for Region 17 within 7 days from the date of this Decision. *North Macon Health Care Facility*, 315 NLRB 359 (1994). The list must be of sufficiently large type to be clearly legible. I shall, in turn, make this list available to all parties to the election.

In order to be timely filed, such list must be received in the Regional Office, Suite 100, 8600 Farley, Overland Park, Kansas 66212, on or before November 29, 2010. No extension of time to file this list shall be granted except in extraordinary circumstances, nor shall the filing of a request for review operate to stay the requirement here imposed. Failure to comply with this requirement shall be grounds for setting aside the election whenever proper objections are filed. The list may be submitted by facsimile transmission. Since the list is to be made available to all parties to the election, please furnish a total of two copies, unless the list is to be submitted by facsimile, in which case no copies need be submitted. To speed preliminary checking and the voting process itself, the names should be alphabetized (overall by department, etc.) If you have questions, please contact the Regional Office.

VII. RIGHT TO REQUEST REVIEW

Under the provisions of Section 102.67 of the Board's Rules and Regulations, a request for review of this Decision may be filed with the National Labor Relations Board, addressed to the Executive Secretary, 1099 14th Street, N.W., Washington, D.C. 20570-0001. This request must be received by the Board in Washington by 5:00 p.m. (ET) on **December 6, 2010**.

This request may be filed electronically through E-Gov on the Agency's website, www.nlrb.gov, but may not be filed by facsimile. Refer to the Attachment supplied with the Regional Office's initial correspondence for guidance in filing electronically. Guidance for E-filing can also be found on the National Labor Relations Board web site at www.nlrb.gov. On the home page of the website, select the E-Gov tab and click E-Filing. Then select the NLRB office for which you wish to E-File your documents. Detailed E-filing instructions explaining how to file documents electronically will be displayed.

SIGNED at Overland Park, Kansas, this 22nd day of November 2010.

/s/ Daniel L. Hubbel
Daniel L. Hubbel, Regional Director
National Labor Relations Board
Seventeenth Region
8600 Farley Street - Suite 100
Overland Park, Kansas 66212-4677